Maricopa County
Pharmacy Program Appeal Form

[Please Print Legibly]

EMPLOYEE INFORMATION

Employee's Name _____

Pharmacy Plan ID # _____

Mailing Address _____

City, State, Zip Code _____

Day Time Phone # _____ **Evening Phone #** _____

Email Address _____

PATIENT INFORMATION

Name _____ **Date of Birth** _____

Relationship to Employee _____

PRESCRIBING PHYSICIAN INFORMATION

Name _____

Address _____

City, State, ZIP _____

Phone # _____ **Fax #** _____

PHARMACY INFORMATION

Pharmacy Name _____ **Phone #** _____

Medication Name _____ **Prescription #** _____

1. Please tell us what you are appealing. (Please use the back of this form if more space is needed to answer these questions.)

2. Please tell us what you would expect the results of this appeal to be.

3. Please explain why you think your appeal should be approved. Provide substantiating medical documentation, as appropriate.

4. Please attach a copy of your denial letter with this completed form.

Signature of Insured **Date**

Please make a copy of this completed form for your personal records.

Send this completed form to:

Employee Health Initiatives
Benefits Office
301 West Jefferson, Suite 201
Phoenix AZ, 85003
602-506-1010 / Fax: 602-506-2354
benefitsservice@mail.maricopa.gov

Form last updated on 3/06/2003: Ver002